FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036921

Facility Name: STRIVE

Address: 415 A STREET (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: 815-537-5358 **Fax #** 815-537-2328

IDPA ID Number: 237136038003

Date of Initial License for Current Owners: 04/09/91

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3610

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2002 to 06/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) ALAN GAPINSKI

(Title) CEO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) 815 778-3610 Fax # 815 778-4503

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 16

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,559			5,559	13
14	TOTALS	5,559			5,559	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.19%

D. How many bed-hold days during this year were paid by Public Aid?
281 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 04/09/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/09/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided ____

Medicare Intermediary ____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

* All facilities other than governmental must report on the accrual basi

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	53,447	2,189	186	55,822	353	56,175		56,175			1
2	Food Purchase		36,009		36,009		36,009		36,009			2
3	Housekeeping	7,335	3,243		10,578		10,578		10,578			3
4	Laundry	1,227	628		1,855		1,855		1,855			4
5	Heat and Other Utilities			14,756	14,756		14,756	(1,195)	13,561			5
6	Maintenance	20,927	7,258	9,796	37,981	1,266	39,247	(121)	39,126			6
7	Other (specify):*											7
8	**TOTAL General Services**	82,936	49,327	24,738	157,001	1,619	158,620	(1,316)	157,304			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	277,281	20,251	20,977	318,509	(960)	317,549		317,549			10
10a	Therapy			75	75		75		75			10a
11	Activities	21,722	2,449	325	24,496		24,496		24,496			11
12	Social Services	30,682			30,682		30,682		30,682			12
13	Nurse Aide Training					2,603	2,603		2,603			13
14	Program Transportation		1,708		1,708	1,597	3,305		3,305			14
15	Other (specify):* DENTAL SERVICES			2,347	2,347		2,347		2,347			15
16	**TOTAL Health Care and Programs**	329,685	24,408	26,724	380,817	3,240	384,057		384,057			16
	C. General Administration											
17	Administrative			106,750	106,750		106,750	(27,562)	79,188			17
18	Directors Fees											18
19	Professional Services			17,313	17,313		17,313	1,479	18,792			19
20	Dues, Fees, Subscriptions & Promotion			3,034	3,034		3,034	124	3,158			20
21	Clerical & General Office Expense	30,057	3,936	6,256	40,249		40,249	16,989	57,238			21
22	Employee Benefits & Payroll Taxe			68,403	68,403	(1,537)	66,866	13,752	80,618			22
23	Inservice Training & Educatior			711	711	(576)	135		135			23
24	Travel and Seminar			2,618	2,618	(2,451)	167	62	229			24
25	Other Admin. Staff Transportatior							187	187			25
26	Insurance-Prop.Liab.Malpractice			8,033	8,033		8,033	123	8,156			26
27	Other (specify):*											27
28	**TOTAL General Administration**	30,057	3,936	213,118	247,111	(4,564)	242,547	5,154	247,701			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	442,678	77,671	264,580	784,929	295	785,224	3,838	789,062			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number STRIVE #0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			38,218	38,218	(1,149)	37,069	6,696	43,765			30
31	Amortization of Pre-Op. & Org											31
32	Interest			19,199	19,199		19,199	171	19,370			32
33	Real Estate Taxes			2,266	2,266		2,266		2,266			33
34	Rent-Facility & Grounds			48,000	48,000		48,000		48,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			107,683	107,683	(1,149)	106,534	6,867	113,401			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					854	854		854			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,709	60,709		60,709		60,709			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			60,709	60,709	854	61,563		61,563			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	442,678	77,671	432,972	953,321		953,321	10,705	964,026			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(1,195)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient	(121)	6		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,684	30		9
10	Interest and Other Investment Incom				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salar				12
13	Sales Tax				13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 4,368		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organizatio Costs (Schedule VII)	6,337		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 6,337		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 10,705		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport	X		$ 854	38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 854		47

STRIVE

ID# 0036921

Report Period Beginning: 07/01/2002

Ending: 06/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,195)	0	0	0	0	0	0	0	0	0	0	(1,195)	5
6	Maintenance	(121)	0	0	0	0	0	0	0	0	0	0	(121)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,316)	0	0	0	0	0	0	0	0	0	0	(1,316)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	79,188	(106,750)	0	0	0	0	0	0	0	0	(27,562)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,479	0	0	0	0	0	0	0	0	0	1,479	19
20	Fees, Subscriptions & Promotions	0	124	0	0	0	0	0	0	0	0	0	124	20
21	Clerical & General Office Expenses	0	833	16,156	0	0	0	0	0	0	0	0	16,989	21
22	Employee Benefits & Payroll Taxes	0	10,511	2,673	568	0	0	0	0	0	0	0	13,752	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	62	0	0	0	0	0	0	0	0	0	62	24
25	Other Admin. Staff Transportation	0	187	0	0	0	0	0	0	0	0	0	187	25
26	Insurance-Prop.Liab.Malpractice	0	123	0	0	0	0	0	0	0	0	0	123	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	92,507	(87,921)	568	0	0	0	0	0	0	0	5,154	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,316)	92,507	(87,921)	568	0	0	0	0	0	0	0	3,838	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STRIVE # 0036921 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,684	1,012	0	0	0	0	0	0	0	0	0	6,696	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	171	0	0	0	0	0	0	0	0	0	171	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,684	1,183	0	0	0	0	0	0	0	0	0	6,867	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,368	93,690	(87,921)	568	0	0	0	0	0	0	0	10,705	45

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES INC	100.00%	BIG MEADOWS INC.	SAVANNA	LYNDON PROGRESS		DAY TREATMENT
	100.00%	PLEASANT VIEW	MORRISON	CENTER	LYNDON	REHABILITATION
MANAGEMENT ONLY	0.00%	WINNING WHEELS, INC.	PROPHETSTOWN			
				LYNDON PLAY &		CHILD DAYCARE
				LEARN CENTER	LYNDON	
				FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	LIVING FACILITY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		CHILD DAYCARE	$	LYNDON PLAY AND LEARN CENTER	100.00%	$ 568	$ 568	1
2	V	17	PROFESSIONAL SERVICES	106,750	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	93,690	(13,060)	2
3	V		PROFESSIONAL SERVICES		LYNDON PROGRESS CENTER	100.00%	18,829	18,829	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 106,750			$ 113,087	$ * 6,337	14

*** Total must agree with the amount recorded on line 34 of Schedule VI**

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AMERICAN HEALTH ENTERPRISES, INC.		DIRECT						$		1
2	ALAN GAPINSKI	PRESIDENT	MANAGEMENT	100.00							2
3	(100% OWNER OF AMERICAN HEALTH ENTERPRISES)										3
4								MANAGEMENT FEES			4
5	S.T.R.I.V.E.			0.00	11,465	5	10.00	FEES	106,750	17/3	5
6	PLEASANT VIEW			100.00	22,930	10	20.00		117,194		6
7	BIG MEADOWS			100.00	32,100	14	28.00		136,012		7
8	WINNING WHEELS			0.00	41,275	18	36.00		196,600		8
9	OTHER (NON-REPORTING)			0.00	6,875	3	6.00		124,050		9
10											10
11											11
12											12
13								TOTAL	$ 680,606		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: AMERICAN HEALTH ENTERPRISES, INC.
Street Address: 501 6TH AVE WEST
City / State / Zip Code: LYNDON, IL. 61261
Phone Number: (815-778-3683
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 55,940	$ 55,940	1	$ 55,940	1
2	17	ADMINISTRATIVE	GROSS REVENUE	11,468,000	5	278,001	278,001	959,000	23,248	2
3	22	BENEFITS	DIRECT COST	1	1	3,569	0	1	3,569	3
4	22	BENEFITS	% OF SALARIES	527,291	5	46,165	0	79,292	6,942	4
5	19	DATA PROCESSING	GROSS REVENUE	11,468,000	5	17,687	0	959,000	1,479	5
6	19	ACCOUNTING	GROSS REVENUE	0	5	0	0	0	0	6
7	20	DUE,FEES,SUBSCRIPTIONS	GROSS REVENUE	11,468,000	5	1,485	0	959,000	124	7
8	21	SUPPLIES,PHONE	GROSS REVENUE	11,468,000	5	9,965	0	959,000	833	8
9	24	TRAINING, SEMINAR	GROSS REVENUE	11,468,000	5	739	0	959,000	62	9
10	25	ADMIN. TRANSPORTATION	GROSS REVENUE	11,468,000	5	2,240	0	959,000	187	10
11	26	INSURANCE	GROSS REVENUE	11,468,000	5	1,466	0	959,000	123	11
12	30	DEPR'N VEHICLES	GROSS REVENUE	11,468,000	5	8,487	0	959,000	710	12
13	30	DEPR'N EQUIPMENT	GROSS REVENUE	11,468,000	5	3,611	0	959,000	302	13
14	32	INTEREST VEHICLES	GROSS REVENUE	11,468,000	5	2,046	0	959,000	171	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 431,401	$ 333,941		$ 93,690	25

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization LYNDON PROGRESS CENTER
Street Address 501 6TH AVE. W.
City / State / Zip Code LYNDON, IL 61261
Phone Number (815-778-3610
Fax Number (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	ADMINISTRATIVE SALLARIE	GROSS REVENUES	5,865,925	6	$ 99,732	$ 99,732	950,242	$ 16,156	1
2	22	BENEFITS	GROSS REVENUES	5,865,925	6	16,503		950,242	2,673	2
3										3
4										4
5		BENEFITS	% DAY CARE FEES	31,314	5	3,845		4,623	568	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,080	$ 99,732		$ 19,397	25

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IL HEALTH FACILITIES		X	MORTGAGE	VARIES	11/29/90	$ 381,000	$ 178,000	8/15/10	6.00-7.75	$ 19,199	1
2	FINANCING AUTHORITY											2
3												3
4	AMCORE BANK				$624.50	1/2001	30,000		01/2006	9.0000	171	4
5	HOME OFFICE ALLOCATION		X	VEHICLES								5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$624.50		$ 411,000	$ 178,000			$ 19,370	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 411,000	$ 178,000			$ 19,370	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE Line #

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 526	2
3. Under or (over) accrual (line 2 minus line 1).		$ 526	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 1,740	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$ 2,266	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:		
1998	NONE	8
1999	NONE	9
2000	NONE	10
2001	NONE	11
2002	286	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STRIVE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT ALAN GAPINSKI

TELEPHONE 815-778-3610 FAX #: 815-778-4503

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-04-176-013	THERAPY ANNEX	$ 216.60	$ 216.60
2.	21-04-176-009	PARKING LOT	$ 263.38	$ 263.38
3.	21-04-176-002	GARAGE	$ 124.16	$ 124.16
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 604.14	$ 604.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,022 B. General Construction Type: Exterior SIDING Frame WOOD/SPRINKLER Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1991	$ 10,207	1
2	GARAGE/PARKING		1995-2002	21,744	2
3	TOTALS			$ 31,951	3

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1991	$ 377,675	$ 9,442	40	$ 15,107	$ 5,665	$ 115,248	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MIXING VALVE			1992	1,840	46	40	92	46	556	9
10	EMERGENCY LIGHTING			1992	723	18	40	18		218	10
11	LANDSCAPING			1992	1,075	27	40		(27)	326	11
12	SIDEWALK & PATIO			1993	2,578	64	40	64		716	12
13	CARPET			1993	1,690	169	10	169		1,662	13
14	STORAGE SHED			1994	2,920	146	20	146		1,472	14
15	ROADWAY			1995	2,556	183	15	183		365	15
16	PAINTING			1997	1,625	163	10	163		1,070	16
17	SIGN			1997	179	9	20	9		60	17
18	CARPET			1997	621	62	10	62		409	18
19	LANDSCAPING			1997	520	52	10	52		342	19
20	CARPET			1997	4,575	458	10	458		3,012	20
21	GARAGE			1997	1,608	80	20	80		529	21
22	GARAGE			1998	36,165	1,447	25	1,447		8,438	22
23	SHOWER			1998	3,322	166	20	166		913	23
24	CARPETTING			1998	1,753	321	5	321		1,753	24
25	BATHROOM TILE & SHOWERS			2000	5,386	539	10	539		1,885	25
26	SIDEWALK & PATIO			2001	1,113	56	20	56		162	26
27	PARKING LOT			2001	4,972	497	10	497		1,326	27
28	FRONT SIDEWALK			2001	5,817	291	20	291		461	28
29	CEMENT SPLASH BLOCKS			2001	1,066	27	40	27		52	29
30	SIDEWALKS			2001	12,478	320	40	320		560	30
31	VINYL FENCING			2001	8,745	875	10	875		1,312	31
32	STEPS			2001	1,150	29	40	29		49	32
33	DRAINAGE & GRADING			2001	4,794	240	20	240		380	33
34	SLIDING DOOR			2001	4,274	214	20	214		338	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WINDOW SHADES & BLINDS	2002	$ 3,629	$ 518	7	$ 518	$	$ 778	37
38	CARPET	2002	14,041	2,006	7	2,006		3,009	38
39	FENCING	2002	1,334	89	15	89		96	39
40	STEPS & SIDEWALKS TO PARKING LOT	2002	4,770	238	20	238		318	40
41	REHAB ANNEX LEASEHOLD IMPROVEMENTS:								41
42	LIGHTING AND ELECTRIC ADDITIONS	2002	9,298	238	39	238		357	42
43	WATER SOFTENER & PLUMBING	2002	1,977	51	39	51		76	43
44	DOOR AND WINDOW UPGRADES	2002	1,885	48	39	48		72	44
45	SIDING & BRICK FACIA	2002	6,924	178	39	178		267	45
46									46
47	STANLEY AUTOMATIC DOORS	2003	18,120	906	20	906		906	47
48	CARPET IN RESIDENTS ROOMS	2003	3,982	284	7	284		284	48
49	REPLACE FIRE DOORS	2003	2,458	123	20	123		123	49
50	WALLCOVERINGS	2003	23,358	1,168	20	1,168		1,168	50
51	HAB AID STATION AND COUNTERS	2003	2,221	111	20	111		111	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 585,217	$ 21,899		$ 27,583	$ 5,684	$ 151,179	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 131,654	$ 14,110	$ 14,110	$		$ 76,793	71
72	Current Year Purchases	11,031	1,060	1,060			1,060	72
73	Fully Depreciated Assets	3,320					3,320	73
74	RELATED PARTY ALLOCATION			302	302			74
75	TOTALS	$ 146,005	$ 15,170	$ 15,472	$ 302		$ 81,173	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MEDICAL APPOINTMENT	DODGE VAN 1992	1992	$ 31,845	$	$	$	5	$ 31,845	76
77	RELATED PARTY ALLOCATION					710	710			77
78										78
79										79
80	TOTALS			$ 31,845	$	$ 710	$ 710		$ 31,845	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 795,018	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,069	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,765	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,696	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 264,197	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: JAMES BIRKLEBAW
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	THERAPY	2001	NONE	12/2001	48,000	5	N/A	5
6	ANNEX							6
7	TOTAL				$ 48,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 12/2001
    Ending 11/2006

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/2004	$ 48,000
13.	6/2005	$ 48,000
14.	6/2006	$ 48,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ N/A Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		50		50
3	Classroom Wages (a)		728		728
4	Clinical Wages (b)		1,455		1,455
5	In-House Trainer Wages (c)		370		370
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 2,603	$	$ 2,603
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,603			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 250	$ 493,555	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 11,289 /115,050)	68,018	876,649	3
4	Supply Inventory (priced at COST)	8,812	46,217	4
5	Short-Term Investments		1,996,999	5
6	Prepaid Insurance	2,586	15,774	6
7	Other Prepaid Expenses	13,042	23,415	7
8	Accounts Receivable (owners or related parties)	47,708	1,132,308	8
9	Other(specify): RENTAL DEPOSIT	8,000	566,661	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 148,416	$ 5,151,578	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		6,416	12
13	Land	31,951	272,861	13
14	Buildings, at Historical Cost	541,856	7,399,370	14
15	Leasehold Improvements, at Historical Cost	43,361	151,204	15
16	Equipment, at Historical Cost	177,850	1,959,876	16
17	Accumulated Depreciation (book methods)	(264,198)	(3,771,519)	17
18	Deferred Charges	4,862	7,411	18
19	Organization & Pre-Operating Costs		22,848	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(22,848)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCT IN PROGRESS		2,465	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 535,682	$ 6,028,084	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 684,098	$ 11,179,662	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 12,899	$ 143,305	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		205,359	29
30	Accrued Salaries Payable	29,920	228,739	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,590	11,581	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,740	1,740	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	REVENUE BONDS	20,000	20,000	36
37	DUE TO/FROM OTHER FUNDS		1,132,308	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 66,149	$ 1,743,032	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,770,266	40
41	Bonds Payable	158,000	158,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	PA ADVANCE FOR DT		49,029	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 158,000	$ 1,977,295	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 224,149	$ 3,720,327	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 459,949	$ 7,459,334	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 684,098	$ 11,179,661	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 402,319	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 402,319	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	57,630	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 57,630	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 459,949	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 1,011,811	1
2	Discounts and Allowances for all Level	(1,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,010,611	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient	121	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 121	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION CHARGES	219	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 219	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,010,951	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	157,001	31
32	Health Care	380,817	32
33	General Administratior	247,111	33
	B. Capital Expense		
34	Ownership	107,683	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	60,709	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 953,321	40
41	**Income before Income Taxes (line 30 minus line 40)****	57,630	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 57,630	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,934	2,254	21,722	9.64	9
10	Activity Assistants					10
11	Social Service Worker	2,008	2,080	30,682	14.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,624	6,302	53,447	8.48	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Worker	1,972	2,144	20,927	9.76	17
18	Housekeepers	877	980	7,335	7.48	18
19	Laundry	150	164	1,227	7.48	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,105	2,305	30,057	13.04	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	25,276	27,435	277,281	10.11	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	39,946	43,664	$ 442,678 *	$ 10.14	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	3	$ 188	1,3	35
36	Medical Director	24	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	390	7,800	10,3	38
39	Pharmacist Consultant	12	480	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	325	11,3	44
45	Social Service Consultant				45
46	Other(specify) DENTAL FEES		2,346	15,3	46
47	PSYCHOLOGICAL	1	75	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	443	$ 14,214		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,031	12,699	10,3	52
53	TOTAL (lines 50 - 52)	1,031	$ 12,699		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNE DUNBAR			$
(SALARY INCLUDED IN MANAGEMENT FEES- LINE 17, COL. 3)			

TOTAL (agree to Schedule V, line 17, col. 1) $
(List each licensed administrator separately.)

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 106,750

TOTAL (agree to Schedule V, line 17, col. 3) $ 106,750
(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
		$
JOHN PYSE	COMPUTER CONSULTANT	5,052
CREATIVE SOLUTIONS	MED REC SOFTWARE MAIN	2,440
JCM CONSULTING	H.R. SOFTWARE MAINT.	820
DATACRAFT/CDW	SOFTWARE UPGRADES	2,679
MIDWEST AUTOMATED TIME	TIME CLOCK SOFTWARE M	400
INTERNET SERVICES, INC.	INTERNET SERVICES	237
LINDGREN, CALLIHAN,VANOS	AUDIT	5,685

TOTAL (agree to Schedule V, line 19, column 3) $ 17,313
(If total legal fees exceed $2500 attach copy of invoices.)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 9,480
Unemployment Compensation Insurance	
FICA Taxes	32,955
Employee Health Insurance	8,953
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE & DISABILITY INSURANCE	6,142
RETIREMENT	2,900
CHILDCARE	4,623
PHYSICALS	70
MISC EMPLOYEE BENEFITS	1,743
RELATED PARTY LPC	3,241
RELATED PARTY AHE, INC.	10,511
TOTAL (agree to Schedule V, line 22, col.8)	$ 80,618

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	101
Health Care Worker Background Check	
(Indicate # of checks performed)	
CARF FEES	1,280
SUBSCRIPTIONS	1,140
PRINTING	113
RELATED PARTY ALLOCATION	124
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,158

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	167
Seminar Expense	
RELATED PARTY ALLOCATION	62
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 229

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING	8/01	$ 4,988	5	$	$	$ 499	$ 998	$ 998	$ 998	$ 998	$ 497	$
2	PAINTING	8/02	1,523	5				151	305	305	305	305	152
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,511		$	$	$ 499	$ 1,149	$ 1,303	$ 1,303	$ 1,303	$ 802	$ 152

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **NO**

(2) Are there any dues to nursing home associations included on the cost repor **YES**
If YES, give association name and amount **ILLINOIS HEALTH CARE ASSOC. $821**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **NO** If YES, have these cost
been properly adjusted out of the cost report

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year **NO** If YES, what is the capacity

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this perio **6 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **3,823** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports **YES** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **NO**
If YES, give effective date of leas

(9) Are you presently operating under a sublease agreement YES **NO** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **60,709**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee **NO** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **YES**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **NONE** Has any meal income been offset agains
related costs? **NONE** Indicate the amount $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **NO**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **NO** If YES, please indicate the amount of income earned from such
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patient **100%**
d. Have vehicle usage logs been maintained **YES**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use **YES**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report **N/A**
g. Does the facility transport residents to and from day training NO
Indicate the amount of income earned from providing suc
transportation during this reporting period $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm **YES**
Firm Name: **LINDGREN, CALLIHAN & VANOSDOL CPA'S** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **YES** If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fee